



## Coordinating Access to Services for Justice-Involved Populations

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### Foreword

There is great interest in improving community-based responses for people with behavioral health and substance abuse conditions—and nowhere is this response more critical than in efforts to support individuals who interact with the criminal justice system. Getting the needed mental health and substance abuse interventions to these people could potentially reduce costs to both the criminal justice and health care systems, provide many more productive years for individuals, and close the revolving door of recidivism.

The Affordable Care Act's Medicaid expansion provides states with the first widespread opportunity to connect adults released from prison or jail with these services. This paper, commissioned by the Reforming States Group (RSG), grew out of the group's interest in the topic. Supported by the Milbank Memorial Fund since 1992, the RSG is a bipartisan group of state executive and legislative leaders who, with a small group of international colleagues, meet annually to share information, develop professional networks, and commission joint projects.

Since many leaders in state and local jurisdictions are directly responsible for the justice-involved population in their communities, they continue to look for innovative ways to provide services and improve health and other outcomes. This paper aims to help state and local leaders better understand the innovations currently taking place as they work to improve the continuum of care for the justice-involved population.

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## Introduction

For participating states, Medicaid expansion under the Affordable Care Act (ACA) provides the first widespread opportunity to connect adults released from prison or jail with needed physical and behavioral health services. The justice-involved population is disproportionately male, minority, poor, and suffers from high rates of mental and substance abuse disorders. Providing critical physical and behavioral health services to this population has many benefits, including the potential to disrupt the cycle of recidivism plaguing the justice system and reduce avoidable health care costs.

Since the implementation of Medicaid expansion in January 2014, a number of jurisdictions have embarked on concerted efforts to connect the justice-involved population with health insurance coverage through Medicaid. This is a great step forward, but Medicaid enrollment cannot, by itself, improve the health of the population. In this paper, we examine how innovative players at the intersection of health and corrections are taking health for the justice-involved to the next level—mainly by providing various comprehensive care coordination interventions to ensure access to physical and behavioral health services as justice-involved individuals transition into their communities. Some of these interventions include peer supports, case management, and integrated mental health, substance abuse, and social supports.

In addition to focusing on implementing Medicaid enrollment for the justice-involved, this paper looks at how services are provided and coordinated and at the strategies used for care coordination. The paper also examines the literature on evidence-based and promising programs for the treatment of mental health and substance use disorders for the justice-involved population and the authorities under which states can target these services.

In conjunction with policies intended to stabilize health insurance coverage for individuals cycling in and out of the justice system, policymakers are beginning to see incarceration less as a barrier to care and more as an opportunity to manage orderly transitions in care, not entirely dissimilar to what should occur at discharge from a hospital.

## Background

Across the United States, more and more stakeholders are seeking to make major reforms to the criminal justice system. Some of this momentum is created by recent events—mass shootings in schools and churches and high-profile incidents between the police and the policed—that highlight needed changes in the interactions among the public, community-based health and mental health services, and the criminal justice system. President Barack Obama has made criminal justice reform a key priority of his administration. Recent efforts in Congress, including the Second Chance and Excellence in Mental Health Acts, underscore an unusually bipartisan interest in redressing some of the excesses in sentencing and in buttressing behavioral health services for those at risk of criminal justice involvement.

Central to much of this conversation is the fact that issues related to behavioral health conditions—mental health and substance use disorders—are at the heart of many individuals' interactions with the criminal justice system. Ever since the deinstitutionalization of patients in psychiatric hospitals in the 1970s and 1980s, there has been inadequate provision of community-based services for individuals with serious behavioral health conditions, who too often are without options for community-based treatment. Fifty percent of inmates in prisons<sup>1</sup> and over 65% of those in jails<sup>2</sup> have substance use disorders, and 20% to 30% have serious mental illness.<sup>3</sup> Once released, prisoners have an increased risk of death compared to the general population. In a 2013 study of over 76,000 prisoners released from the Washington State Department of Corrections between 1999 and 2009, Binswanger et al. found that death rates among former prisoners were 3.6 times that of the general population and 10 times the expected rate of death due to overdose. Individuals were at greatest risk of overdose death in the first week after release.<sup>4</sup>

Efforts are underway to improve community-based responses to behavioral health conditions, ranging from increased availability of the anti-overdose drug naloxone (Narcan) in public settings such as schools and in the hands of paramedics and police officers, to increased integration between physical and behavioral health providers. However, addressing behavioral health conditions as individuals interact with the criminal justice system may be the most critical area for action. A positive impact on an individual with serious mental illness involved with the criminal justice system could reduce costs to both the criminal justice and health care systems, provide additional productive years of life for society, and close the revolving door of repeat arrest due to relapse of a behavioral health condition.

Before the passage of the ACA, addressing behavioral health conditions was complicated by the patchwork availability of insurance coverage, particularly for low-income adults. In most states, adults without dependent children had limited access to publicly insured care. Additionally, most states terminated an individual's Medicaid coverage upon incarceration, even when he or she was simply in jail awaiting trial or sentencing, potentially due to an inability to post bail. As a result, nearly 90% of individuals arriving in jail before the ACA had no health insurance,<sup>5</sup> and by the time they were transferred to prison or released from jail, nearly all had lost any access to health insurance.

Care of inmates is usually delivered through providers contracted directly by individual jails or prisons or via contracts with correctional health providers that may administer services for many correctional facilities. However, federal Medicaid law prohibits payment for services provided to inmates within the “four walls” of a correctional facility. The “inmate exception” allows Medicaid to pay for inpatient hospital services if an inmate is admitted to an inpatient facility such as a hospital, nursing home, or psychiatric facility for greater than 24 hours, but state eligibility systems often erect barriers to these payments. Prior to the ACA, individuals could receive services in jail or prison for the substance abuse and mental health conditions that may have contributed to their incarceration, though the extent or quality of those services may have been limited. But with little access to health insurance outside the jail or prison, they had little to no access to coverage-based behavioral health services upon release.

The ACA has begun to dramatically change this dynamic. Thirty-two states (including the District of Columbia) have expanded Medicaid to all legally residing adults ages 18 to 64 below 138% of the federal poverty level, which is approximately \$16,000 for an individual income. When Medicaid eligibility and enrollment are established for those involved in the criminal justice system, a range of potential payment and service possibilities open up that can reduce a state or county’s payment burden (i.e., by increasing Medicaid payment for services), while increasing access to necessary services. A significant proportion of individuals involved in the criminal justice system are very likely to be eligible for Medicaid. At the end of 2014, an estimated 6.8 million individuals were under the supervision of the US corrections system, or 1 in 36 adults.<sup>6</sup> Of those individuals, 4.7 million were under community supervision (probation or parole), while 1.5 million were in prison and another 750,000 were in local jails. Each year, local jails admit an estimated 11 million people.<sup>7</sup> For US citizens and legal immigrants in jail and prison, with little to no income to report, eligibility for Medicaid coverage in an expansion state is nearly a sure bet.

## Enrollment of the Justice-Involved

Under the ACA, 100% of the services provided to individuals enrolled under the Medicaid expansion are paid for by the federal government from 2014 through the end of 2016, with states required to pick up 5% of the bill in 2017, gradually increasing to 10% by 2020. Even in 2020 and beyond, this represents a significant source of potential savings for states and counties, which are otherwise responsible for 100% of health care and supportive services costs for this population. States that did not cover this population through Medicaid in the past would see the greatest gains from the additional federal funding and ensuing reductions in uncompensated care.

Recognizing the coverage opportunities that the ACA provides, efforts to enroll the justice-involved in Medicaid are accelerating across the nation. This work received a recent boost from the Center for Medicaid and CHIP Services (CMCS) with the release of the State Health Official Letter 16-007, the first formal federal guidance on Medicaid coverage for the justice-involved since 1997.<sup>8</sup> In a set of 30 questions and answers, CMCS addressed

questions related to: the definition of an inmate for purposes of the inmate exclusion; the continued applicability of eligibility and enrollment policies for inmates; and the services covered under the inpatient exception. Most important for enrollment purposes, the letter said that state Medicaid agencies “must accept applications from inmates to enroll in Medicaid or renew Medicaid enrollment during the time of their incarceration,” and if all eligibility requirements are met, “must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility.”

In implementing enrollment for inmates, states often first target inpatient hospitalizations that last more than 24 hours. Two methods of enrollment may be used: completion of a full application for Medicaid, either prior to an expected hospitalization or soon after the fact; and use of presumptive eligibility, which allows for a limited period of Medicaid eligibility. Because of the limited window of active benefits that presumptive eligibility provides (generally no more than two months), many states initially pursue this option for inmates to guard against paying improper Medicaid claims or capitated payments to managed care plans while an individual is still incarcerated.

In states where efforts are underway to enroll justice-involved individuals in Medicaid wherever they come in contact with the justice system, completion of a full application, by paper or electronically, is often preferred. CMCS’s recent guidance leans toward use of the full application, recommending that states suspend coverage through markers and edits in claims processing systems to prevent payment of improper claims and establish timely reporting with their Medicaid managed care plans to prevent capitated payments for individuals who are incarcerated. Presumptive eligibility requires follow-up to ensure a full application is completed for coverage to continue; completing the full application at the outset may ensure a more streamlined connection to services during transitions through the justice system.

Taking advantage of Medicaid enrollment for inpatient hospitalization represents a relatively small policy shift for states, but one that can provide dividends in state and local criminal justice-based savings for expensive hospital stays. Colorado, Michigan, and Ohio have seen savings of \$5 million to \$13 million a year for the same type of initiative.<sup>9</sup>

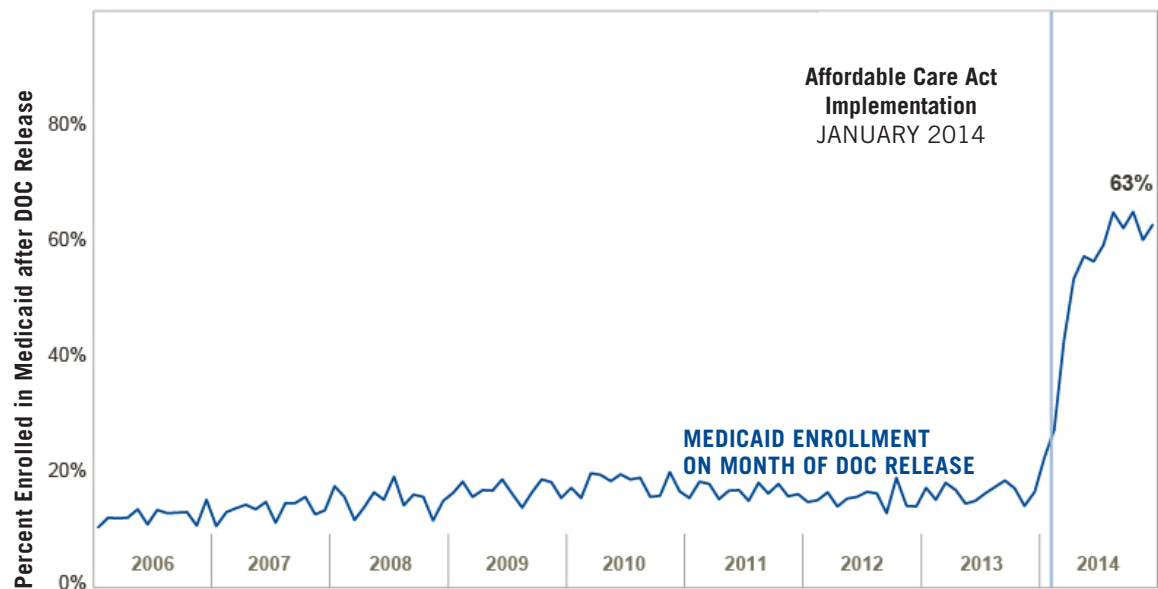
The next logical step for Medicaid enrollment, particularly in expansion states, is to determine where to place enrollment efforts for larger populations of the justice-involved. Early consideration should be given to activities that can be coordinated with existing correctional processes. Enrollment at intake to a jail or prison may be attractive due to the positive control exerted over the individual at that point but may be complicated by the chaotic environment at intake, as well as the mental state of an applicant, who may have an uncontrolled mental health or substance abuse condition. Enrollment on release may take place in an environment of reduced chaos but may increase the likelihood that an inmate leaves without adequate connection to the health care system, particularly for jail systems where individuals may be discharged directly from a court hearing rather than returning to jail.

Some of the most successful programs for Medicaid enrollment, such as those conducted at the Cook County Department of Corrections in Illinois, use a “belt and suspenders” method, integrating enrollment staff into the intake process and also checking with inmates as they leave the facility to ensure Medicaid enrollment.

Pretrial diversion (such as drug, mental health, and veterans’ courts), probation, and parole provide other promising enrollment opportunities. Diversion programs provide court-ordered alternatives to incarceration for offenders who may benefit from treatment, particularly for mental health or substance use conditions. Medicaid enrollment as a condition of release can facilitate connections to the health care system and provide an additional source of funding for treatment services, which may help avoid future expensive jail and prison stays. A study conducted in Washington state in 2009 found \$9,000 to \$18,000 in corrections savings per low-income adult provided treatment for alcohol and substance use disorder.<sup>10</sup> For other individuals on probation (not through a diversion program) and those on parole, probation and parole officers can connect individuals to Medicaid coverage and help coordinate access to services. Because individuals in these programs are required to check in with the corrections system regularly, it presents another avenue of “positive control” to ensure connection to the health care system and other community services.

Few states have publicly released enrollment numbers for the justice-involved population, perhaps due to the politics associated with coverage for the population. Writing in *Health Affairs* in 2014, Marsha Regenstein and Sara Rosenbaum estimated that 25% to 30% of people released from jail would enroll in Medicaid in expansion states, and 20% in Marketplace coverage.<sup>11</sup> In a 2012 study using similar methodology, Cuellar and Cheema estimated that approximately 30% of prison inmates would enroll in Medicaid through the Medicaid expansion.<sup>12,13</sup> But these conclusions rely heavily on take-up rate assumptions. New York and Colorado have estimated that 80% and 90%, respectively, of state prison inmates were likely eligible for Medicaid as of 2014. Data from 2006 to 2014 in Washington state show a jump from less than 20% enrollment in Medicaid upon release before the ACA to more than 60% after implementation of the Medicaid expansion (see Figure 1).<sup>14</sup> In Cook County, Illinois, while only 16% of jail inmates contacted by enrollment assisters refused enrollment in September 2013 due to already having coverage, by December 2014 nearly 60% of inmates stated they already had coverage.<sup>15</sup> These higher rates of Medicaid enrollment may be attributed to intensive enrollment efforts by enrollment assisters in the community and by justice-focused enrollment efforts behind bars.

Figure 1. Medicaid Enrollment Following Release from DOC Correctional Facility  
Washington State Department of Corrections Releases, Calendar Year 2006 Through 2014



Source: Guyer J., Bachrach D., Shine N. *Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States*. State Health Reform Assistance Network. November 2015.

## Providing Services to the Justice-Involved

Enrollment in Medicaid coverage is a critical step to ensuring that individuals with justice involvement have access to services needed to successfully transition back into the community, particularly for those with mental health and substance abuse disorders. Once enrollment processes are established, states should ensure that the appropriate benefits are available to treat the prevalent conditions and that there is appropriate coordination of services.

All state Medicaid programs are required to provide a suite of mandatory services including inpatient hospitalization, nursing facility services, and laboratory and x-ray services. They may also choose to offer (and almost all do) a suite of optional services (including prescription drugs, physical/occupation/speech therapies, emergency hospital services, etc.) through their state plans. The behavioral health services that are most commonly offered under the mandatory categories include inpatient hospital, outpatient hospital, and physician services. Optional services generally have included prescription drugs, diagnostic, screening, preventive and rehabilitative services (the rehab option), and case management.

For expansion states, services provided to the Medicaid expansion population (of which the majority of the justice-involved are a part) must be through an alternative benefit plan (ABP), which must include services in the 10 essential health benefit (EHB) categories. This requirement was an attempt to provide continuity with qualified health plans provided in the commercial health insurance marketplace, while also ensuring a robust suite of services for what was originally intended as a pared-down benefit. The EHB categories are listed in Table 1; the EHB requirement for coverage of mental health and substance use disorder services is particularly relevant to the justice-involved population.

Table 1: Ten Essential Health Benefits in the Affordable Care Act

1. Ambulatory Patient Services	6. Prescription Drugs
2. Emergency Services	7. Rehabilitative and Habilitative Services and Devices
3. Hospitalization	8. Laboratory Services
4. Maternity and Newborn Care	9. Preventive and Wellness Services and Chronic Disease Management
5. Mental Health and Substance Use Disorder Services	10. Pediatric Services, including Oral and Vision Care

Through the state plan amendment process with the Centers for Medicare & Medicaid Services (CMS), states may implement multiple ABPs, tailoring benefits to the needs of diverse subsets of the expansion population. To date, however, most states have implemented plans that conform closely to their state plans for traditional Medicaid populations. Starting in 2017, states will begin to pay a greater share of the costs for the expansion population, which may prompt states to reexamine how the services provided through an ABP match with the needs of the various expansion subpopulations.

Other models that states may use to select and target mental health and substance use benefits to justice-involved populations are described below:

- Health Home for Enrollees with Chronic Conditions (Section 2703 of the ACA).** This Medicaid state plan option offers states enhanced federal medical assistance percentages (90% federal match for the first eight fiscal quarters from the effective date of the state plan amendment) to provide coordinated care to individuals with chronic conditions, especially those with mental health and substance use disorders. Six core services must be offered by the health home: comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, individual



and family support, and referral to community and social support services. In addition, states can identify additional services as “core” to the model. States can target health home enrollment by condition and geography but cannot target enrollment by criteria such as age, delivery system, or dual eligibility status.

- **State Plan Home and Community-Based Services (HCBS) (Section 1915(i)).** As modified through Section 2402 of the ACA, Section 1915(i) of the Social Security Act gives states an opportunity to provide state plan HCBS to individuals with mental health and substance use disorders before individuals need institutional care. By submitting a state plan amendment to CMS for approval, states can target the HCBS benefit to one or more populations and define the services included in the benefit. Approval for a specific population is granted for a five-year window.
- **Section 1115(a) Demonstration Projects.** Section 1115 waivers allow states to propose programs that may waive certain provisions of Medicaid, enabling states to target select populations or geographic sites and test innovative policy and delivery approaches. Demonstration costs that Medicaid might not otherwise cover may be approved under this authority. California’s recently approved Medi-Cal 2020 waiver includes Whole Person Care pilots that provide counties with new options to provide coordinated care for vulnerable, high-utilizing Medicaid recipients, including the justice-involved.<sup>16</sup> It also allows counties to provide extended stays for withdrawal and residential substance use disorder services for criminal justice offenders if assessed for need and builds upon investments in post-incarceration transition to integrated care through the state’s previous Delivery System Reform Incentive Payment program.

Medicaid coverage through ABPs or delivered through managed care must also follow the Mental Health Parity and Addiction Equity Act, which requires insurance plans that cover behavioral health disorders to offer coverage that is no more restrictive than that provided for medical or surgical services, including scope of benefits, financial requirements, treatment limits, and lifetime and annual dollar limits. Through a final rule published on March 30, 2016, CMS expanded mental health parity to all Medicaid managed care plans and all ABPs and the Children’s Health Insurance Program, regardless of delivery system.<sup>17</sup> As a result, new Medicaid enrollees (including the justice-involved) should have access to a wide scope of behavioral health benefits, particularly to address substance use disorders. However, parity regulations relate to services that have a medical or surgical equivalent, so support services (e.g., peer supports, supportive housing, and employment, etc.) may not be guaranteed. An additional inpatient benefit that may be important in states that provide Medicaid through managed care is the recently finalized rule by CMS to allow federal financial participation for treatment of 15 days or less within an institution for mental disease.<sup>18</sup>

However, Medicaid programs must always be aware of the fiscal implications of changes to benefits offered. Encouraging the implementation of evidence-based practices for behavioral health, including fidelity to the evidence-based model, may help states tailor their benefits to reduce the likelihood that justice-involved individuals decompensate, and in turn face arrest, while ensuring adequate treatment across all populations.

There is extensive literature on evidence-based practices for mental health and substance abuse conditions, yet no direct cause or link has yet been identified between a particular practice and reduction of recidivism, a complex social problem with many interrelated causes and potential solutions. In a 2005 assessment of jail diversion programs for individuals with serious mental illness, Steadman and Naples theorized that lack of access to evidence-based practices may be one impediment that keeps treatments from having any real impact on recidivism.<sup>19</sup> Additionally, as practices are adapted to the criminal justice environment, their effectiveness may change.

To understand how evidence-based practices in the justice system could be adapted to the treatment of mental illness, the national GAINS Center for Behavioral Health and Justice Transformation convened six expert panels to identify practices that can have an effect on health and public safety outcomes for persons involved in the criminal justice system.<sup>20</sup> Practices reviewed included assertive community treatment; supportive housing; trauma-specific interventions; supportive employment; illness self-management and recovery; and integrated mental health and substance abuse services. In review of these treatment categories, integrated treatment for co-occurring disorders, supportive housing, and assertive community treatment were identified as having the highest potential impact on criminal justice outcomes. Building on this work, Blandford and Osher in 2012 collected a range of evidence-based and promising practice for the Substance Abuse and Mental Health Services Administration that researchers, experts, and practitioners identified as being applicable for adults involved in the criminal justice system.<sup>21</sup> They define promising practices as “those that are associated with positive outcomes, but do not yet have an evidence base.” These services are identified in Appendix 1.

Many of these services rely heavily on peer supports (e.g., forensic peer specialists, peer-based recovery supports); case management (e.g., assertive community treatment, forensic intensive case management); or integrated mental health, substance abuse, and social supports. The following section explores real-world examples of health care systems attempting to address the complex needs of the justice-involved population, often including efforts to connect with individuals before they are released from jail or prison.

## Coordinating Services for the Justice-Involved

As previously discussed, enrollment in coverage does not guarantee access to services for the justice-involved. Similarly, and particularly for the subset of the justice-involved with mental health or substance use disorders, availability of services does not directly translate to use of those services. Cultural competency in health care has long been touted as a means of reducing disparities in access to and quality of health care.<sup>22</sup> This becomes particularly important for the justice-involved, who may leave prison or jail with little desire or opportunity to reengage with formal systems of care. Culturally competent providers and care coordinators, including peer navigators, may help address factors such as race, ethnicity, and gender that add complexity to the transition from incarceration to civilian life.

And although the previous section highlights services provided primarily through physical and behavioral health systems, efforts to identify and improve conditions related to social determinants of health—such as housing, education, and employment—may be even more important to facilitating reintegration. A number of programs developed over the past few years were designed to facilitate connections between individuals in jails and prisons and needed health care and social services. A selection of these programs are profiled below.

### Transitions Clinic Network

The Transitions Clinic Network (TCN) provides medical homes to individuals with chronic illness (including substance abuse) released from prisons and offers culturally competent care in part by employing community health workers (CHWs) with a history of incarceration. The first Transitions Clinic opened in 2006 in San Francisco, and the network has expanded, in part through a \$6.8 million Health Care Innovations grant from the Innovation Center, to 14 sites in seven states and Puerto Rico. The TCN model integrates the services of physicians, social workers, and CHWs stationed at health centers or primary care clinics to provide physical and behavioral health care and referral to community resources for formerly incarcerated individuals. CHWs provide key outreach and coordination services, meeting individuals at parole encounters and in their homes, identifying critical social needs (e.g., clothing, housing, government identification), and guiding them through the health care system while addressing their physical and behavioral health needs. By helping ensure that these individuals keep their appointments, CHWs also help the clinics they serve by reducing no-shows and increasing efficiency.

Results of the TCN model have been promising. In a randomized controlled trial reported in the *American Journal of Public Health* in 2012, rates of emergency department utilization among TCN patients in San Francisco were 35% lower than among patients at other primary care sites.<sup>23</sup> Recent efforts across the country to promote the financing of CHWs through Medicaid and other means provide even greater promise for ongoing expansion of the TCN model.

### New York State Criminal Justice Health Homes

In another take on medical homes for the justice-involved, the state of New York implemented a Criminal Justice Health Home Demonstration in six of its 37 health homes. Funded under Section 2703 Health Home for Enrollees with Chronic Conditions as described earlier, these six programs enroll justice-involved individuals with one or more of the following conditions: serious mental illness, two or more chronic conditions (including substance use disorder), and/or HIV/AIDS. Goals of the demonstration include providing integrative care across medical and social service providers; effective communication through use of health information technology; patient engagement to improve health literacy and meet patient preference; and providing care with cultural sensitivity. Health homes are reimbursed for outreach and engagement of eligible members and for ongoing care management once enrolled.

A critical component of the care coordination efforts in these health homes is the collaboration among organizations responsible for the justice-involved population. At Rochester-based Huther Doyle Memorial, the lead provider for Health Homes of Upstate New York Finger Lakes, the Monroe County sheriff and district attorney serve on the board, smoothing connections to criminal justice entities for the Finger Lakes health home. In New York City, the Maimonides Brooklyn Health Home has a long relationship with the New York City Department of Health and Mental Hygiene, facilitating the implementation of data transfer agreements between the organizations.

Maimonides Brooklyn provides an example of how information technology can identify the justice-involved and facilitate connections. Through an extensive data exchange with the Department of Health and Mental Hygiene, the criminal justice director at Maimonides runs reports multiple times a day from a data set that matches the entire global census of the health home to the Rikers Island jail census, identifying health home members that are in active outreach, enrolled in care, discharged, or not identified. The director provides alerts to over 400 care management providers in the Maimonides network to reach out or follow up with individuals as they move through the Rikers Island system. This facilitates strong connections between care managers and individuals, which reduces the likelihood that the individual will be lost to follow-up.

### Other Promising Programs

A number of other programs being implemented across the country show promise for improving outcomes and reducing recidivism for the justice-involved:

- **The Hennepin County (Minnesota) Criminal Justice Behavioral Health Initiative** includes an integrated access team of social workers, chemical health counselors, housing specialists, and CHWs. This team works with the sheriff's office and medical staff at the Hennepin County jail to make contact with individuals with significant mental health needs in jail and to maintain contact after release to help link them to community services. Funded by the state of Minnesota through the CMS State Innovation Models (SIM) grant program, this program is being evaluated through SIM for its ability to: increase health care coverage for high-need clients; reduce use of emergency department services; increase use of community-based services; provide for early identification of behavioral health needs; decrease recidivism; and increase coordination and communication across county systems.
- **The San Diego County Prisoner Reentry Program** brings together the county probation department, sheriff's department, health and human services agency, and Medicaid providers to facilitate Medicaid enrollment. This supports the probation department's development of a comprehensive individualized case plan and referral of justice-involved individuals to community-based organizations for physical and/or behavioral health treatment or other support services. Initially started through an outreach and enrollment grant from The California Endowment, San Diego accelerated its program

by establishing memoranda of understanding between the involved agencies to quickly place application assisters from health and human services at jail and probation sites. To facilitate case plans and referrals, San Diego conducted educational sessions with community-based organizations to promote interest in connections between clinical providers and jail and probation sites.

- **The Miami-Dade County (Florida) Criminal Mental Health Project** is a pre-arrest, post-book- ing diversion program that provides access to mental health treatment with the support of case managers and peer specialists as an alternative to jail time. It also includes training for all members of the Miami-Dade Police Department in the crisis intervention team model for appropriate responses to mental illness. The project has drastically reduced the number of arrests associated with mental illness in the county and has reduced recidivism rates for individuals booked for misdemeanor crimes to less than 20% from approximately 72% before the program and to approximately 6% among individuals in the felony diversion program.<sup>24</sup> Initially funded through grants from the Substance Abuse and Mental Health Services Administration and then through the state of Florida, the project continues to receive support from Miami-Dade County, the Florida Department of Children and Families, and grants to fund case management positions, housing, medications, and transportation for participants.
- **The Restoration Center at the Center for Health Care Services (Bexar County, Texas)** provides residential detoxification, sobering, outpatient substance abuse treatment, and in-house recovery to individuals struggling with alcohol and drugs. Combined with crisis intervention team training, this program and its associated jail diversion program have diverted over 17,000 people from jails and emergency departments, saving Bexar County taxpayers over \$10 million a year. The Restoration Center is funded through a combination of local and state resources, including the city of San Antonio, Bexar County, the University Health System, and the Texas Department of State Health Services.<sup>25</sup>

## Key Strategies for Care Coordination for the Justice-Involved

In many states, including those that have embraced the opportunity for health insurance coverage through Medicaid expansion, there have been concerted enrollment efforts focused on the justice-involved population, such as elimination of policies designed to terminate Medicaid coverage when an individual is in jail. These are the first steps for improving the physical and behavioral health of the justice-involved. As we have seen in Texas, Florida, and elsewhere, if a state does not expand Medicaid and cover this population, other systems can lead efforts to coordinate access to services. These can include community-based organizations or reinvestments from the justice system itself. When building care coordination capacity for the justice-involved, jurisdictions should consider the following key strategies:

## 1. Identify Organizations with Experience with the Justice-Involved

Experience with the barriers and challenges that the justice-involved face, particularly when a behavioral health disorder is involved, is critical to developing trusting relationships. This trust can improve the likelihood that an individual follows through with recommended treatment upon release. “Warm transfers” between systems, in which staff receive detailed information about individuals before transfer to ensure that critical services or connections are not missed, are highly encouraged. As one person interviewed for this paper noted, “You have one chance with this population—if you don’t show that you can deliver, they move on.”

## 2. Implement Evidence-Based Services to Address Critical Needs

There is general consensus that services that address the multiple needs of the justice-involved—including physical, behavioral, and social needs—are the most likely to reduce recidivism and improve the chances of successful reintegration with society. Each of the models described above includes some combination of an integrated care team, peer supports, or integrated physical, behavioral, and social supports. In states that have expanded Medicaid (and have addressed capacity issues), the adult justice-involved population will have access to a wide range of these services, but other programs that focus on this population have shown positive impact by reducing costs associated with emergency department visits and repeat jail stays, providing justification for payment through other systems, such as justice reinvestment.

## 3. Use Information Technology to Identify and Facilitate Connections

Integrated systems to identify and track the justice-involved as they move in and out of the justice system and other social services programs can help programs better identify where connections have been made or might be missed. By addressing those missed connections, programs may improve an individual’s trust of these formal systems and allow them to take better advantage of the services available.

In summary, any effort to improve the care of the justice-involved requires coordination among many entities—from human service programs and corrections departments, to community-based organizations and departments of probation and parole—that may not have had a history of strong collaboration. Identifying champions—particularly those, such as judges, with the ability to influence a justice-involved individual’s course through the justice system—can go a long way toward convincing systems to work together. As more examples of this collaboration rise and bear fruit, either functionally or financially, the more they will be emulated by others across the country and the more likely it will be that the revolving door of incarceration for individuals with behavioral health disorders will begin to slow.

Appendix 1: Evidence-Based (EB) and Promising (P) Services for Treatment of Behavioral Health Conditions in the Criminal Justice System

Treatment	Addresses Mental Health	Addresses Substance Abuse and Dependence
<p><b>12-Step or Other Mutual Aid Groups</b> Groups of nonprofessionals who share a problem and support one another through the recovery process.</p>		P
<p><b>Assertive Community Treatment (ACT)</b> Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs.</p>	EB	
<p><b>Forensic ACT (FACT)</b> ACT-like programs that have been adapted for people involved in the criminal justice system and focus on preventing arrest and incarceration.</p>	EB	
<p><b>Behavioral Couples Therapy (BCT)</b> A family treatment approach for couples that uses a “recovery contract” and behavioral principles to engage both people in treatment, achieve abstinence, enhance communication, and improve the relationship.</p>		EB
<p><b>Case Management</b> An intervention that involves the coordination and/or direct delivery of services to meet the complex needs of justice-involved clients with substance use disorders.</p>		P
<p><b>Cognitive Behavioral Therapy (CBT), Including Targeting to Criminogenic Risk</b> A therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behaviors through brief, direct, and time-limited structured counseling. May also be designed to address criminogenic risks and may focus on anger management, problem solving, and assuming personal responsibility for behavior.</p>	EB, P for Targeting	EB, Targeting not listed
<p><b>Contingency Management (CM) Interventions</b> The objective of CM interventions is to reinforce a client's commitment to abstinence and to reduce his or her drug use using positive (e.g., vouchers) and negative (e.g., increased supervision) reinforcers in response to desired and undesired behaviors.</p>		EB

<p><b>Forensic Intensive Case Management (FICM)</b> Like FACT, FICM involves the coordination of services to help clients sustain recovery in the community and prevent further involvement with the criminal justice system. Unlike FACT, FICM uses case managers with individual caseloads as opposed to a self-contained team.</p>	EB	
<p><b>Forensic Peer Specialists (aka Peer-Based Recovery Support)</b> Justice-involved clients who are in recovery provide support to other clients who are also involved, or at risk of becoming involved, in the criminal justice system.</p>	P	
<p><b>Illness Management and Recovery (IMR)</b> An approach that involves teaching clients skills and techniques to minimize the interference of psychiatric symptoms in their daily lives.</p>	EB	
<p><b>Integrated Mental Health and Substance Abuse Services</b> Treatment and service provision to support recovery from co-occurring mental illness and substance abuse through a single agency or entity.</p>	EB	
<p><b>Modified Therapeutic Community (MTC)</b> MTCs alter the traditional therapeutic community approach in response to the psychiatric symptoms, cognitive impairments, and other impairments commonly found among individuals with co-occurring disorders. These modified programs typically have: (1) increased flexibility, (2) decreased intensity, and (3) greater individualization.</p>		EB
<p><b>Motivational Enhancement Therapy (e.g., Motivational Interviewing)</b> A consumer-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.</p>	EB	EB
<p><b>Medication-Assisted Treatments (e.g., Pharmacotherapy/ Psychopharmacology)</b> Treatment that uses one or more medications as part of a comprehensive plan to reduce symptoms associated with dependence on drugs and/or alcohol (pharmacotherapy) or reduce depression, psychosis, or anxiety by acting on the chemistry of the brain (psychopharmacology).</p>	EB	EB
<p><b>Relapse Prevention Therapy</b> A systematic treatment method of teaching recovering clients to recognize and manage relapse warning signs.</p>		EB



<p><b>Supported Employment</b> An evidence-based program for people with severe developmental, mental, and physical disabilities that matches them with jobs and trains them so their specific skills and abilities make them valuable assets to employers.</p>	EB	
<p><b>Supportive Housing</b> A system of professional and/or peer supports that allows a person with mental illness to live independently in the community. Supports may include regular staff contact and the availability of crisis services or other services to prevent relapse, such as those focusing on mental health, substance abuse, and employment.</p>	EB	

*Adapted by Center for Health Care Strategies from: Blandford, A. and Osher, F. A Checklist for Implementing Evidence-Based Practices and Programs (EBPs) for Justice-Involved Adults with Behavioral Health Disorders. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation; 2012.*

## Notes

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## About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness. [www.milbank.org](http://www.milbank.org)

## About the Reforming States Group

The Reforming States Group (RSG) is a nonpartisan, voluntary group of state health policy leaders from both the executive and legislative branches who, with a small group of international colleagues, gather regularly to share information, develop professional networks, and commission joint projects—all while using the best available evidence and experience to improve population health. Supported by the Milbank Memorial Fund since 1992, the RSG brings together policymakers who usually do not meet together outside their states, to share information they cannot obtain anywhere else. RSG members say that their involvement in the group makes them better able to perform as public servants. <http://www.milbank.org/our-work-with-states/reforming-states-group>